Children's Disability Services Workgroup

Meeting # 1
October 1, 2013
10:00 am to 3:00 pm
Polk County River Place
2309 Euclid Avenue
Des Moines, Iowa

MINUTES

Attendance

Workgroup members: Jim Ernst, Chuck Palmer, Gail Barber, Nicole Beaman (pm), Paula Connolly, Deb Dixon, Patty Erb, Jerry Foxhoven, Jason Haglund, Sheila Kobliska, Janice Lane, Scott Musel, Amber Rand, Wendy Rickman (am), Jason Smith, Shanell Wagner (pm), Sen. Nancy Boettger, Sen. Liz Mathis.

Workgroup members absent: Marilyn Althoff, Dana Cheek, Nick Juliano, Marilyn Lantz, Debra Waldron, Susan Walkup, Rep. Lisa Heddens, Rep. Joel Fry

Facilitator: Kevin Martone, Kelley English

DHS/IME Staff: Theresa Armstrong, Karen Hyatt

Other Attendees:

Sue Lerdal	Disabilities Policy Council,
Judy Collins	Iowa Nurses Association
Beth Rydberg	Disability Rights Iowa
Rhonda Rairden	Iowa Department of Public Health
Vicki Miene	Center for Child Health, University of Iowa
Ryan Santi	Sequel
Josh Bronsnick	Senate Staff
Kelley Pennington	Magellan
Melissa Havig	Magellan
Marni Busel l	IME
Laura Larkin	DHS
Jim Donahue	Iowa Department of Education
Kristi Oliver	Coalition for Family and Children Services
Susie Osby	Polk County Health Services
Vickey Vermie	Telligen

Aaron Todd	State Senate
Don Gookin	DHS/IME
Andy Eastwood	MHCONI
Susan Fenton	LS2Group
Sandi Hurtado Peters	DOM
John Pollak	LSA
Janice Lane	CFI
Brad Whipple	YESS

Charge of the Workgroup / Legislation

SF452 Sec. 185 CHILDREN'S SERVICES. The department of human services shall reconvene the children's services workgroup initially created by the department of human services pursuant to 2011 Iowa Acts, chapter 121, section 1, and continued pursuant to 2012 Iowa Acts, chapter 1120, section 26. The workgroup shall complete its deliberations to develop a proposal for publicly funded children's disability services and make a report with recommendations and findings to the general assembly on or before November 15, 2013. The workgroup, in consultation with affected stakeholders, shall consider options for appropriately consolidating or eliminating state councils or bodies that oversee, monitor, or provide input into policy which involves publicly funded children's services.

Director Palmer encouraged the workgroup to focus on what to do with the most difficult young people in terms of placement and available services. The private and public sector must partner to put together a program to deal with a no reject no eject of children and the private sector must continue to strengthen their capacity to deal with the most difficult youth population. It will be imperative the workgroup develop new ideas on how to effectively serve these children populations. The tasks that need to be addressed by the workgroup in the next two meetings are:

1. The System of Care approach through the Integrated Health Home model and what lessons are being learned.
2. What degree are these lessons a major building block for the children in the system of care?
3. What does the creation of the Children's Cabinet mean for an integrated children's mental health system?

Workgroup Overview

Jennifer Vermeer, Medicaid Director shared an update on integrated health homes and out of state placements of children. Complexity and range of solutions is required when planning for children's mental health services. The Integrated Health Home (IHH) is one of the strategies and not the total of the solution, although is a tremendous new effort

Services for children with mental health disorders have the highest rate of dollars spent compared with infectious disease at the low end of the rate chart.

Adults with chronic mental illness die 25 to 30 years earlier than their peers who do not have a mental health condition, often due to unaddressed physical conditions. Prevention is the key.

IHH provides a team of professionals working together to provide whole-person, patient-centered, coordinated care for all situations in life and transitions of care to adults with SMI and children with SED.

An SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the DSM diagnostic criteria and results in functional impairment. Magellan claims information identified 16,000 eligible children for an IHH. 800 of these children are covered by the children's mental health waiver and will receive care coordinated through the IHH.

Team Approach

The IHH is not a place; it is a team approach to delivery of care coordination services. The team has a set of unique skills based on education and experience. The team works on care coordination, health and wellness education, resource direction, family support services and transitional care support.

A Children's IHH will use a family centered, strengths-based approach, comprehensive care management, care coordination using wraparound approach, health promotion, comprehensive transitional care, individual and family support services, referral to community and social support services.

At the community system level the IHH utilize local systems of care with a community child health team convening wraparound process and linkages to community based services, school based preventative services, building local systems of care with focus on prevention, early intervention, community preparedness and population health activities

At the state system level the pediatric managed behavioral health organization utilizes innovations regarding health information technology, expansion of tele-health services, data analysis, system payment reform and state level collaboration, coordination and monitoring.

Phase One started July 1, 2013. The IHH is expected to engage with the attributed members within 90 days. Finding the eligible children has been a challenge as DHS does not always have the correct addresses which make it difficult to find the families.

Additional IHH sites starting October 1, 2013

- Lifeworks in Polk and Warren counties
- Youth Emergency Services and Shelter (YESS) in Polk and Warren counties
- Community Services Advocate (CSA) in Polk and Warren counties
- Hillcrest in Dubuque County

The IHH team roles and responsibilities:

Magellan:

- Selects IHH providers
- Provides care management support through claims-based reporting to identify gaps in care, risk analysis and development of online tools to support daily service delivery and population management needs.

Community IHH Providers:

- Develop care teams to work with members
- Use data and technology to oversee and intervene in the total care of the member
- Work with community services and support to address member/family needs
- Develop whole-health approaches for care

Kelley Pennington, Director of IHH from Magellan shared additional information on the implementation of IHH.

- The IHH model is a care coordination model. Team members including nurses, peer support specialists whose sole job responsibility is to provide the support and coordination for the member. There are a lot of providers involved in the coordination and the family is well supported.

- Intensive care level remains the same as prior Systems of Care approach – which engages natural supports and community partners. More people are having a role in the child's life and there are better partnerships within the community partnerships. IHH is a bigger system than just the team.

- Targeted Case Management is a model with one person doing everything and IHH is a very different model. The care coordinators have different contract requirements than the targeted case managers. If the care coordinators are providing the role of case management through a waiver – they have to follow the case management plan detail.

PMIC responsibility was transitioned to Magellan in 2012 and the average placements per month numbers have dropped. It is recognized there is more that needs to be done however the model so far is viewed as successful.

Magellan staff meets regularly with the PMIC directors. 4 Oaks has changed its staff operations to meet the needs of children and other providers are engaging in the conversation. The providers have to change their training for staff and this is a huge commitment on the part of the provider. The goal is not just reducing length of stay but creating. Magellan can provide flexibility, have conversations and pay differently than IME can.

Comments / questions from the workgroup:

One part of the building blocks to put this together is that in many areas you can't take one thing away and replace with something else. Care Coordination is the key to keep people out of PMICS and institutions. What happens where the delivery services available haven't changed to meet the needs of the person? A different array of services needs to be there than what is currently available.

Children can receive the IHH model if they are Medicaid eligible, this creates a point of accountability and data will show where the gaps of needed services are. IHH will also create partnerships to have the conversation about how to serve the needs of children better in their own communities. Seeing where the gaps are, identifying the needs, and creating a conversation to achieve outcomes will be areas to build upon in the future. Performance measures are built in to the model. IHH have to achieve outcomes and have incentive payments tied into it.

What are the range of services needed in the IHH system and how are the services prioritized and built into the system?

There are online training tools are available and staff have learned many things regarding the tools and are constantly making changes.

Communication steps are important on when to engage the varying entities. Engagement and when to engage need to be flexible.

Foster parent communication, have questions on who can sign for the child to participate in the IHH. Providers can share information although there is a barrier within provider boundaries.

There is concern that families will misunderstand IHH decline services. There is wrong information in the field which causes confusion even though public education was conducted.

With limited information it is hard for families to make decisions. Historically people were getting bits and pieces of information that didn't make sense.

Consumer groups have been tremendously helpful to educate the families that the IHH is not a place and that it is a team model and approach.

The IHH really is a transformational process. It takes time to go through the CMS process. Even with good intention it takes time to change patterns and retrain service workers on a new concept. Identifying the lack of services is also a key.

Director Palmer briefly discussed the mental health redesign process and indicated that some regions have already committed to pooling of dollars and others have not. There is a lot happening in the month of October; new IHH providers start October 1st, it is also the first day of enrollment for the Iowa health and wellness program which will be a change in the current delivery system. With the changes, question will arise such as where the IHH will fit within the other system changes? How the IHH will fit with the ACO and how a broad scale system medical change formula will be utilized. IHH will need to figure out how to adapt to a Medicaid model and how to fit with the Accountable Care Organization's coordinated delivery system's payment systems, and how to manage the expectation of a population health management. The contracting and payment for a range of outcomes (ACO) are not inconsistent with IHH and ACO formats and are building blocks toward what Iowa needs to achieve. IHH is a contract with an entity that becomes responsible for the members served, with outcomes and a total cost of care measure. Other entities will also be expected to manage outcomes of people with mental illness and these outcomes should connect with IHH.

IHH will be a significant asset to the ACO strategy in a delivery system for healthy outcomes. Safety net providers have been worried about the ACO being large hospital centric tied to a traditional model. Iowa envisions a more holistic model and a set of partners in the community that will work with the ACO and the IHH.

Jim Ernst indicated that Four Oaks did not anticipate how hard it would be to find the qualifying families. He also indicated that providers feel the direction is the right one. Integrating mental and physical health is seen as the most effective side to helping the children. The design is there, the system not quite there.

Jerry Foxhoven gave a summary of the Iowa Juvenile Home Task Force he chairs. The Taskforce members want a no eject no reject policy in Iowa. This policy would assist in keeping children closer to home and in their own community. The task force is looking at how prevent a child going to Toledo and how to stop multiple placements with challenges with children going to shelters when a PMIC won't take them. There are children with challenges who the system doesn't know how to help. They can't live at home and end up moving all over the place which creates more traumas. The

taskforce is looking to identify the high end issues and remove the emotion to see what can be done do to create an effective model in Iowa. The taskforce is focused on defining who are the high end children, what creates this definition and feel it is necessary to have clinicians involved in the process along with Magellan. It is believed research needs to guide what happens in the future and validates a choice of model which will produce the best outcomes. There is a feel payment in the system for community based services needs to happen early on in a child's life to prevent a more costly placement later and when an adult.

Public comment:

Judy Collins (Psychiatric Nurse stated she has seen a lot of phases of care over the year and it struck her that a number of things have now been identified for statewide success. Pilots to statewide vision and is wondering if there are places in the system where rural issues are being looked at. She has questions regarding how much money the IHH is going to cost – who is going to provide the money and is the state projecting what the IHH model will look like in places like Red Oak and Maquoketa.

Jennifer Vermeer responded that there are fundamental projections of multi years' worth of funding and there has been much focus on Magellan's reimbursement rates and the projection of members. Magellan understands not all agencies will be ready to provide IHH and will work with providers that aren't ready. The goal and scale of IHH is that it will be regional.

Director Palmer added in rural areas we have to look at what the community ownership is for systems of care and there has to be buy in from families. There needs to be an interface between the children's system and the adult system within each of the regions. Engagement has to happen that will bring in a variety of system changes. Opportunities that come with system changes need to be cognizant of each other.

Susie Osby PCHS commented that we need to keep in mind children are eligible for Medicaid while in the PMIC but when the children transition out of the PMIC, they are no longer eligible for Medicaid, unless their family qualifies for Medicaid. These children will lose the IHH either in the interim period or altogether.

Senator Boettger: To what extent are the AEA and school systems participating within the IHH model?

Kelley Pennington responded that Magellan recognizes the education system has to be involved from day one with children in IHH and with the families and community providers. There needs to be an ongoing introduction to the school systems across the state. The education can provide advocacy and support depending on what the family wants.

Presentations were given by Kevin Martone and Kelly English on State Approaches to Children's System of Care development. They reviewed three states Maryland, Massachusetts, and New Jersey.

Maryland

Mission and Vision statement:

- All Maryland's children will be successful in life (Children's Cabinet)
- Maryland will achieve child well-being through interagency collaboration and state and local partnerships (Governor's Office for Children)
- The Children's Cabinet, led by the Executive Director of the Governor's Office for children, will work collaboratively to create and promote an integrated, community-based service delivery system for Maryland's children, youth and families. The mission is to improve the well-being of Maryland's children.

Organizing structure

Children's Cabinet:

- Promote the vision of the state for a stable, safe and healthy environment for youth
- Provides a forum for state agencies to meet and develop coordinated policy recommendations
- Prepares a 3 year plan for establishing priorities
- Reviews and approves grant applications for the Children's cabinet
- Operates the Interagency Fund

Governor's Office for Children

- Responsible for developing and coordinating the delivery of interagency state government services to youth and families
- Led by an Executive Director appointed by the Governor who also serves as the chairperson of the Maryland's Children's Cabinet

Advisory Council

- Makes recommendations for integrated youth and family programs
- Coordinates with local government, local management boards and private groups

Local Management Boards

- Serve as the coordinators and conveners of collaboration for youth and family services on the local level

- Bring together local child-serving agencies, providers, and family members

University of Maryland Innovations Institute

- Provide training and technical assistance
- Research and evaluation
- Certification of Wraparound practitioners
- Policy analysis

Care Management Entity

- In January, 2012 the Governor's Office for Children issued an RFP to select a statewide care management entity to serve certain youth with intensive needs
- Provide intensive care coordination using a Wraparound service delivery model
- Provide access to family support and youth support partners via a subcontract with family organization
- Facilitate access to community-based service and supports available through local management boards and other community resources
- Administer discretionary and flexible funds and contract for services as needed
- Conduct assessments
- Conduct quality assurance and monitor outcomes
- Paid through a case rate

Service and supports: Care Management Entities facilitate linkages to and contracts as needed with community resources:

- Care Eligibility limited to Medicaid eligible youth with serious emotional disturbance with significant functional impairment
- Case coordination using Wraparound process via Care Coordination Organization
- Child and Family Team participation
- Intensive In-Home Services (must be an evidence-based or promising practice approved by DHMH)
- Mobile Crisis Response
- Community-based respite
- Out-of-home respite
- Peer-to-peer support
- Expressive and experiential behavioral services
- Mental health consultation to health care professionals
- Customized goods and services

Strengths of the system of care approach:

- Coordination of youth-serving agencies at the Governor's Office level
- Funding to support services at the local level available through Children's Cabinet Interagency Fund
- Long history of commitment to SOC values
- Care coordination available for youth with Medicaid and non-Medicaid enrolled youth
- Broad array of services and supports available including family and youth support
- University of Maryland provides training, certification, consultation, policy analysis, research and evaluation

Challenges of the system of care approach:

- Different populations of youth served in different Care Management Entities
- Care Management Entities are not a purchase of services and do not authorize care

Massachusetts

Children's behavioral health initiative governance:

- Coordinate interagency (child welfare, mental health, public health, juvenile justice, education) activities
- Develop referral and collaboration protocols
- Facilitate compliance with state's remedial plan and serve as the liaison for the federal court monitor
- Collaborate with MassHealth Office of Behavioral Health and other stakeholders
- Children's Behavioral Health Advisory Council established via statute
- Membership consists of Commissioners of child-serving state agencies, education, providers, family members, trade organization reps, academics, and managed care reps
- Required to submit and annual report, with legislative and regulatory recommendations to the governor, secretary of health and human services, the commissioner of early education and care, the commissioner of elementary and secondary education, the child advocate and the general court

Community service agencies:

- Managed care entities contract with 32 Community Service Agencies, one for each service area (29) and three culturally and linguistically-focused

- Deliver Intensive Care Coordination and Family Support and Training using the Wraparound care coordination model
- Convene and staff the local System of Care Committee

Care coordination for youths with varying needs: Clinical Hubs

Intensive Care Coordination (Wraparound)

- Clinical Assessment including CANS
- SED determination for eligibility
- Medical Necessity determination
- Care Coordination

In-Home Therapy

- Clinical Assessment including CANS
- Medical necessity determination
- Care coordination available

Outpatient Therapy

- Clinical Assessment including CANS
- Medical necessity determination
- Care coordination available
-

Families decide on most appropriate initial service independently or in consultation with helping professions such as primary care, mental health clinicians, schools, case workers, community organizations, faith based leaders and others. Additional services offered are behavior management therapy and monitoring, family support and training, therapeutic mentoring, partial hospital, inpatient hospital and inpatient diversion.

The care planning team creates individual care plans utilizing mobile crisis intervention, in home therapy services, in home behavioral services, therapeutic mentoring, family support and training, 24 hour acute care and outpatient care.

Strengths of the System of Care approach:

- Use of evidence-based care coordination model in Wraparound
- Care coordination available for youth with different intensities of need
- Strong array of Medicaid behavioral health services and supports
- Sustainable funding stream through Medicaid state plan
- No wrong door entry for youth
- Statewide service access
- Common assessment used across all service providers

- Neither CSAs nor the MCEs purchase or authorize non-Medicaid services or supports making it difficult to leverage these supports on behalf of youth
- Six MCEs with differing authorization and billing practices places administrative burden on providers
- Continuity of care can be a challenge when a youth loses MassHealth

New Jersey

The System of Care governance includes:

- Child protection and permanency
- Children's System of Care
- Family and community partnerships
- Women
- Adolescent services
- Advocacy
- Education
- Licensing
- Performance Management and Accountability
- Institutional abuse investigation unit

Division of Children's System of Care

- Serves youth with emotional and behavioral health care challenges, developmental and intellectual disabilities and serves Medicaid and non-Medicaid eligible youth

University of Medicine and Dentistry of New Jersey Behavioral Health Research and Training Institute

- Develops System of Care curriculum
- Training and technical assistance
- Certification on assessment tools

Medicaid

- Contracted System Administrator for Perform Care
- Single point of entry to obtain behavioral health and IDD services
- Authorize monitor and coordinate care and service outcomes
- Publish reports
- Maintain IT system
- Quality management

- Manage the single payer system – process claims to Medicaid

County-based contracts with family support organizations

- Work with families who need care coordination to assist with advocacy and promote family voice in service planning

Services and supports:

- Mobile crisis response
- Intensive in-home therapy
- Therapeutic foster care
- Functional family therapy
- Behavioral aides
- Multi-systematic therapy
- Group homes
- Residential care
- Flexible funding available to pay for goods and services identified in a plan of care for a youth

Financing:

- Mental health
- Child welfare
- Developmental disabilities
- Medicaid (administrative funds, rehab option, EPSDT, Targeted Case Management)

Single payer system:

- COMOs and Mobile Crisis Response providers can make Medicaid presumptive eligibility determinations
- Blended funding from DCF to Medicaid to administer and pay claims
- Created a Medicaid look-alike program to cover services for no-Medicaid enrolled youth
- Providers submit all claims to the CSA

Strengths of the System of Care approach:

- Single payer system
- Single point of entry
- Services available to Medicaid and non-Medicaid enrolled youth

- Training and research infrastructure to support best practice service delivery
- Training and technical assistance infrastructure
- Flexible funding available to support needs identified in a youth's plan of care

Challenges of the System of Care approach:

- FSOs disconnected with service delivery, serving as advocates as opposed to a peer support service
- Heavy reliance on Medicaid funding makes it challenging to focus on other non-billable activities such as training and quality improvements

Workgroup comments:

- How are cultural competency needs met across the state?
- Magellan pays for language translation
- Plans to use technology to offer services in rural settings. How do social media tools change the service delivery?
- Youth are tied to social media communications. YESS has a pilot to text youth to encourage compliance in visits – paid for text

Chuck Palmer provided guidance to the workgroup in moving forward. The workgroup must identify services and principles and produced a report on a children's mental health system. Some points for considerations and questions to be answered:

- What are the core services on the adult system side?
- Children have the right to services regardless of where they live.
- What is the structure through which these needed services are delivered?
- How will service areas and regions be defined?
- Governance piece, from the state level and the children's cabinet perspective, what will the system look like locally?
- Funding is primarily Medicaid funding based on eligibility, what level of disability and financial eligibility should be considered?
- Is the funding Medicaid and Non-Medicaid?
- Who will be served, the level of qualified disability and income eligibility?
- Who are the providers in the system?
- Who will govern at the local level, how will the governance work and who will govern?
- What will the group define as core eligibility, how will the Core Plus be included and how do you determine what are the minimum core services.

The workgroup needs to work through prioritization of the list within the next two meetings and produce a coherent plan. Looking at the established core services list for adults would be helpful. The charge is not just for Medicaid eligible children, but for all children as there will be services that Medicaid doesn't pay for but children will still need.

Public Comment

Sue Lerdal representing the Policy of Disability Council discussed how it is costly to the state to grow up to have more difficult needs which IME has data to support. She gave a statement of thanks to DHS, IME and Magellan for all their ongoing work on mental health system for children and adults.

Next Meeting: October 15th 10am to 3pm